EMSC/CHILD READY CONNECTION Newsletter

MARCH VOLUME 2, ISSUE 3

EMS & Trauma Section
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A word from the EMSC Program Manager:

Greetings!

The Emergency Medical Services for Children (EMSC) Program aims to ensure that emergency medical care for the ill and injured child or adolescent is well integrated into an emergency medical service system.

We work to ensure that the system is backed by optimal resources and that the entire spectrum of emergency services (*prevention, emergency response, prehospital care, hospital care, interfacility transport, and rehabilitation)* is provided to children and adolescents, no matter where they live, attend school or travel.

CHILD READY MONTANA—STATE PARTNERSHIP OF REGIONALIZED CARE (SPROC)

The intent of the program is to develop an accountable culturally component and assessable emergent care system for pediatric patients across Montana.

THE RIGHT CARE AT THE RIGHT PLACE AT THE RIGHT TIME WITH THE RIGHT RESOURCES!

Exciting news and events are going on this month.

See What's New!

MONTANA DPHHS Healthy People. Healthy Communities.

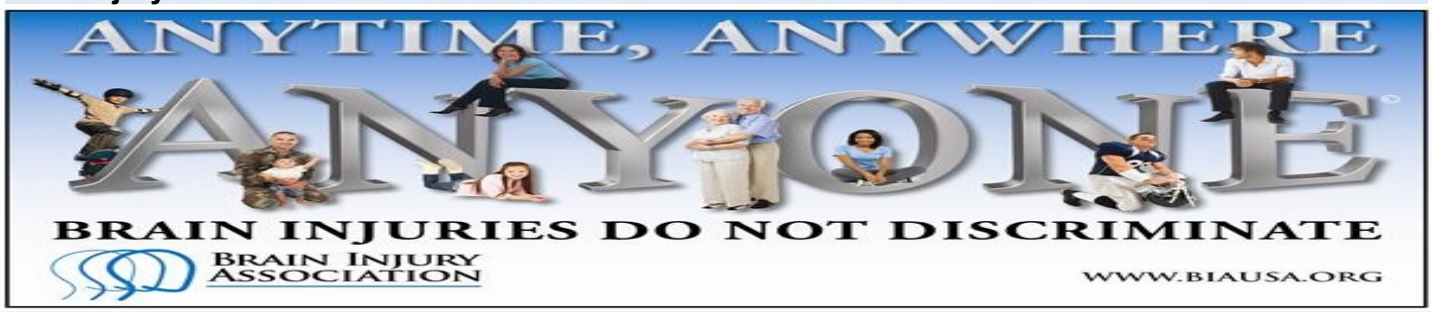
CHILD READY montana

Montana EMS Emergency Care

MARCH IS BRAIN INJURY AWARENESS MONTH

The Brain Injury Association, advocates, families and volunteers across the nation, will mark Brain Injury Awareness Month this March. A brain injury can happen anytime, anywhere, to anyone – a brain injury does not discriminate. In fact, 2.4 million Americans sustain a brain injury each year. Early and equal access to care for all is the goal.

See ideas on how to promote brain injury awareness in your community at http://www.biausa.org/brain-injury-awareness-month.htm



Montana Statistics for Traumatic Brain Injury (a complex injury with a broad spectrum of symptoms and disabilities):

- 2,198 TIB-related deaths in MT between 1999 and 2006.
- Approximately 275 people died from TBI or were seen in the ED and/or doctors' offices.
- 845 patients were admitted to MT hospitals and diagnosed with a TBI in 2006.
- Approximately 25 people a month die from a TBI

http://www.traumaticbraininjury.com/injury-sources/state-resources-for-tbi/montana/

The **Pediatric Glasgow Coma Score** (**PGCS**) is the equivalent of the Glasgow Coma Scale (GCS) used to assess the mental state of child patients. As many of the assessments for an adult patient would not be appropriate for infants, the Glasgow Coma Scale was modified slightly to form the PGCS. As with the GCS, the PGCS comprises three tests: eye, verbal and motor responses. The three values separately as well as their sum are considered. The lowest possible PGCS (the sum) is 3 (deep coma or death) whilst the highest is 15 (fully awake and aware person). The pediatric GCS is commonly used in emergency medical services.
http://en.wikipedia.org/wiki/Paediatric_Glasgow_Coma_Scale

	1	2	3	4	5	6
Eyes	Does not open eyes	Opens eyes in response to painful stimuli	Opens eyes in response to speech	Opens eyes spontaneously	N/A	N/A
Verbal	No verbal response	Inconsolable, agitated	Inconsistently inconsolable, moaning	Cries but consolable, inappropriate interactions	Smiles, orients to sounds, follows objects, interacts	N/A
Motor	No motor response	Extension to pain (decerebrate response)	Abnormal flexion to pain for an infant (decorticate response)	Infant withdraws from pain	Infant withdraws from touch	Infant moves spontaneously or purposefully

PEDIATRIC ABUSIVE HEAD TRAUMA/SHAKEN BABY SYNDROME:

The Center for Disease Control defines Pediatric Abusive Head Trauma (PAHT), as an injury to the skull or intracranial contents of an infant or young child (< 5 years of age) due to inflicted blunt impact and/or violent shaking. Often times referred to as Shaken Baby Syndrome, **PAHT is a leading cause of child abuse deaths** in the United States and babies (newborn to 4 months) are at greatest risk of injury and death from shaking. Nationally, PAHT occurs in an estimated 30 out of every 100,000 children under the age of one. Approximately 25% of all victims die as a result of their injuries. Deaths due to abusive head trauma peak at 1 to 2 months of age, most likely due to higher physiologic vulnerability during early infancy. Infants who have abuse-related head injuries at 3-4 months of age or older may be more resilient and more likely to survive their injuries. Among those who survive, approximately 80% suffer permanent physical and mental disabilities and with that, potential lifetime medical costs reaching an estimated $1,000,000 per victim. SBS statistics are currently unavailable for Montana,

Inconsolable crying is a primary trigger for shaking a baby. Research shows that shaking most often results from crying or other factors that may trigger the person caring for the baby to become frustrated or angry. A new program in Montana is shedding light on SBS/AHT and providing new parents with explanations and remedies. **PURPLE MT is a statewide initiative aimed at SBS/AHT prevention utilizing *The Period of PURPLE Crying Program***. Administered through Healthy Mothers Healthy Babies- MT (HMHB-MT), PURPLE MT is funded through the Montana Children's Trust Fund and the Dennis and Phyllis Washington Foundation.

In 2009, the Montana Legislature passed MCA 50-16-103 & 50-16-104, requiring a state sponsored SBS Prevention Program and distribution of SBS educational materials. In response to the state mandate, and in its mission to ensure a healthy start for all children, HMHB-MT began identifying and pulling together stakeholders and partners to address the issue of SBS in Montana. Subsequent research into evidence-based programs to prevent SBS led to the discovery of the National Center on Shaken Baby Syndrome's program.

The Period of PURPLE Crying, a parent education and support program, began in the fall of 2012. *The Period of PURPLE Crying Program* educates about early infant crying, coping strategies and the dangers of shaking a baby. *The Program* utilizes a three-Dose approach to SBS prevention: **Dose One** is hospital or birthing clinics. **Dose Two** (Reinforcement and reminder of the messages provided in Dose One) is delivered and/or reinforced by public health nurses, physician practices, and home visitor programs within two weeks of delivery and throughout the Period of PURPLE Crying (2-weeks through 6-months.) **Dose Three** is a public education campaign to accomplish a cultural transformation within the general public about the normalcy of early infant crying and the dangers of shaking or hurting a baby.

The Period of PURPLE Crying Program provides consistent SBS prevention messages; educational services that strengthen, support and empower parents and families and serves to ensure a healthy and safe start for all Montana babies. We have begun to **partner with hospitals across Montana** to administer PURPLE education universally to all new parents in their OB departments at discharge (Dose 1). **Of the 29 birthing hospitals and clinics in MT, 17 are now administering the PURPLE Program, representing 62% of MT births. The goal is to reach 80% of MT births by April 2014 at which time the National Center on Shaken Baby Syndrome Prevention will formally recognize Montana as a PURPLE State. We look forward to celebrating with Montana children, families and partners statewide!**

Services provided through PURPLE MT include: Providing community and state partners with information about the National Center on Shaken Baby Syndrome and *The Period of PURPLE Crying Program*; Training opportunities and resources including nurse CEU training; and the 1st year start-up materials (DVD and Booklet) **free of charge** through HMHB-MT and PURPLE-MT for all Dose 1 providers.

To partner with PURPLE MT and for more information about *The Period of PURPLE Crying Program* please call Gail Beckner at Healthy Mothers Healthy Babies-MT, PURPLE MT, 406.449.8611 or visit www.purplemt.org

The *Period of PURPLE Crying* is a new way to help parents understand this time in their baby's life, which is a normal part of every infant's development http://www.purplecrying.info/what-is-the-period-of-purple-crying.php

The Letters in PURPLE Stand for

P	U	R	P	L	E
PEAK OF CRYING	UNEXPECTED	RESISTS SOOTHING	PAIN-LIKE FACE	LONG LASTING	EVENING

SHAKEN BABY SNYDROME/ABUSIVE HEAD TRAUMA TRAINING

National Center on Shaken Baby Syndrome
www.dontshake.org

Basic Training:
Provides a basic understanding of the effects of SBS/AHT (Shaken Baby Syndrome/Abusive Head Trauma) and how we think it can be prevented.

Intermediate Training:
Provides a thorough introduction to the multidisciplinary approach needed when a case of SBS/AHT (Shaken Baby Syndrome/Abusive Head Trauma) is presented. Intended for the professional audience; however, interested laypersons will also benefit from the content. http://www.dontshake.org/lms/lms_information/

CHILD READY montana

PEAK OF RESPIRATORY VIRUS SEASON FOR CHILDREN IS 'DEFINITELY COMING'

How to prevent respiratory syncytial virus or RSV infection

Researchers are working to develop RSV vaccines. However, there are steps to help prevent the spread of RSV. Specifically, people who have cold-like symptoms should

- Cover their coughs and sneezes
- Wash their hands frequently and correctly (with soap and water for 15–20 seconds)
- Avoid sharing their cups and eating utensils with others
- Refrain from kissing others

In addition, cleaning contaminated surfaces (such as doorknobs) may help stop the spread of RSV. Special attention should be paid to protecting children who are at high risk for developing severe disease if infected with RSV. Such children include premature infants, children under age 2 with chronic lung or heart conditions, and children with weakened immune systems.

Ideally, people with cold-like symptoms should not interact with children at high risk for severe disease. But, if this is not possible, they should carefully follow the prevention steps mentioned above, and they should wash their hands before interacting with children at high risk.

When possible, limiting the time that high-risk children spend in child-care centers or other potentially contagious settings may also help prevent infection and spread of the virus during the RSV season.

Source: Centers for Disease Control and Prevention and St. Vincent Healthcare
Read more: http://billingsgazette.com/lifestyles/health-med-fit/it-was-pretty-scary-peak-of-respiratory-virus-season-for/article_3e5524aa-0760-5239-a7c8-16eed8ea4ec8.html#ixzz2v6kLdzX3

HAVE YOU SEEN THE PEDIATRIC TRAUMA RESUSCITATION CHECKLIST TOOL KIT YET? HTTP://BIT.LY/19XE66R

NEW TRAINING APPROACH IMPROVES PEDIATRIC SURVIVAL RATES FOLLOWING CARDIAC ARREST

Researchers at the Stanford University School of Medicine and Lucile Packard Children's Hospital Stanford found a new way to boost the survival of pediatric patients whose hearts stop while they are hospitalized. The researchers developed a broader approach to resuscitation training to include everyone who responds to a pediatric "code" event.

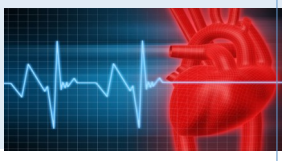
Before the new training was implemented, about 40% of the hospital's "code" patients survived their cardiac arrest, a figure comparable to the national average for children's hospitals. After training, survival jumped to 60%. The study used in-situ simulation to train staff with recreated scenarios from actual cases.

To train everyone, the research team **staged mock codes** in all areas of the hospital where the code team works. Staffers were paged as if there was a real code and did not know until they arrived that they were participating in a simulation. They resuscitated a medical mannequin whose condition could be programmed to improve or worsen depending on the effectiveness of their responses. The simulations were videotaped so that all members of the team could review and discuss their responses after the fact.

One key goal of the training is for one person to quickly assume the role of the code team leader, and for others to take on specific, pre-defined roles in the team's response based on American Heart Association guidelines about best practices for resuscitation. The simulations also provided risk-free opportunities to identify problems in hospital operations. For instance, during one simulation, the code team leaders found that their security badges did not give them access to the portion of the hospital where the simulation was staged.

As a result of the new findings, Lucile Packard Children's Hospital Stanford has made the new training program a permanent part of its resuscitation education. The study's authors hope that other hospitals will make similar changes based on the success of their technique. "With this training in place, responding to codes becomes muscle memory for the whole team," Knight said. "That's what's going to save lives."

Additional Information- The study was funded by an Innovation in Patient Care Grant at Lucile Packard Children's Hospital Stanford. In addition to Knight and Franzon, co-authors included Julia Gabhart, MD, general pediatric hospitalist; Karla Earnest, MS, MSN, trauma program coordinator at the hospital; and Kit Leong, senior quality improvement adviser. Stanford University Medical Center



SPRING FEVER- 18TH ANNUAL SPRING FEVER TRAUMA CONFERENCE

St. Patrick Hospital's Trauma Services is pleased to offer free, high-quality trauma education to the dedicated professionals who provide pre-hospital, clinic, and hospital care throughout Montana. The conference will be held April 12, 2014 at the Hilton Garden Inn Conference Center in Missoula.

The trauma topics are for midlevel practitioners (APRNs, Pas, etc..) clinical staff, and pre-hospital personnel involved in emergency resuscitation and critical care management. The Spring Fever Conference features outstanding speakers who can teach trauma care from their personal experiences and can related to the issues faced in rural Montana such as isolated areas, long distances, extreme weather, delayed discovery, and prolonged transport to a hospital. Participants choose from a variety of sessions, there is something for every medical provider who attends.

Registration opens in March- http://montana.providence.org/hospitals/st-patrick/for-health-care-professionals/education-and--training/spring-fever-trauma-conference/spring-fever-2014/

HEALTH LITERACY FOR PUBLIC HEALTH PROFESSIONALS

Web-based, http://www.cdc.gov/healthliteracy/training/index.html—Hardware/Software-Computer-Internet Format-Web-based program. Contact Information- Cynthia Baur, Ph.D. CDC Office of the Associate Director of Communication, 404-498-6411. **No fees are charged for CDC's CE activities**.

Target Audience- Physicians, Registered Nurses, Nurse Practitioners, Dentists, Pharmacists, Veterinarians, Health Educators, Health Communicators, Public Affairs Specialists, Administrators, Epidemiologists, Public health program managers.

Program Description- The purpose of this public health literacy web-based training program is to educate public health professionals about public health literacy and their role in providing health information and services and promoting public health literacy. This web-based course uses a 508-compliant template, knowledge checks, evaluation, CE and other credits, include glossary and resources tabs, scenario-based interactions and video clips.

Objectives- At the conclusion of the session, the participant will be able to accomplish the following:

1. Define and describe public health literacy.
2. List factors that influence public health literacy.
3. Identify who is affected by public health literacy.
4. Recognize the consequences of limited public health literacy.
5. Determine who are the stakeholders in public health literacy.
6. Recognize the role of public health literacy in meeting core public health services.
7. Apply lessons learned to improve public health literacy.

Accreditation Statements- CME: The Centers for Disease Control and Prevention is accredited by the Accreditation Council for Continuing Medical Education (ACCME®) to provide continuing medical education for physicians. The Centers for Disease Control and Prevention designates this web-based for a maximum of 1.25 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity

Continuing Education Designated for Non-Physicians- Non-physicians may receive a certificate of participation.

CNE: The Centers for Disease Control and Prevention is accredited as a provider of Continuing Nursing Education by the American Nurses Credentialing Center's Commission on Accreditation. This activity provides 1.0 contact hours.

CEU: The CDC has been approved as an Authorized Provider by the International Association for Continuing Education and Training (IACET), 1760 Old Meadow Road, Suite 500, McLean, VA 22102. The CDC is authorized by IACET to offer 0.1 ANSI/IACET CEU's for this program.

CECH: Sponsored by the Centers for Disease Control and Prevention, a designated provider of continuing education contact hours (CECH) in health education by the National Commission for Health Education Credentialing, Inc. This program is designated for Certified Health Education Specialists (CHES) to receive up to 1.0 Category 1 CECH in health education. CDC provider number GA0082.

The Universal Activity Number is 0387-0000-11-097-H04P. Course Category: This activity has been designated as Knowledge-Based.

"SIZZURP"

Doctors are warning of a cough syrup concoction that people are abusing to get high. The mix, which could be deadly, combines soda, candy, and prescription cough syrup. The drink is called— "sizzurp." Doctors are warning that the drug, which is made by combining soda, candy and prescription cough syrup with codeine, can be deadly. It can lead to seizures and essentially lead you to stop breathing." "It's quite addictive," Glatter said. "The sweetness of the soda and candy combined with the drug itself makes people want to have this all day long. ... They just don't know how much they've had throughout the day and by then, it's almost too late."

Also known as "purple drank," "syrup" and "lean," sizzurp typically includes Jolly Rancher candy for color and extra sweetness along with soda and prescription-strength cough syrup. The end product is said to provide an instant, euphoric high. "Kids are seeing this all over — on social media, on the Internet," said Steve Pasierb, president and CEO of *The Partnership at Drugfree.org*. "

A recent U.S. Drug Enforcement Administration report said one in 10 teens admits to using cough syrup or cold medicine to get high. "These are dangerous prescription drugs," Pasierb said. "Whether they're mixed with soft drinks or mixed with Jolly Ranchers, it doesn't change that fact. This is one of the more dangerous ways, frankly, to get high."

The best advice for parents? Experts say it's important to be proactive and warn kids about the dangers of sizzurp, even if you think your teenager would never use it. The drink is popular at parties and appears harmless with its bright colors and sweet taste — but in this case, looks are deceiving.

TIME CHANGE (March 9th)

For the body, the time changes are like jet lag -- causing sleep-deprivation. Even an hour changes your circadian rhythm and this can give you problems for weeks. One expert suggested that people ease into the Time Change by starting a bit early. "The most important thing is to try to change one of the clocks on Friday and start following that clock to eat meals, sleep and wake according to that clock. When Monday comes you will be better adjusted," said Dr. Praveen Rudraraju, director of the Center for Sleep Medicine at Northern Westchester Hospital in Mt. Kisco, N.Y.

Common problems such as sinus issues, snoring or sleep apnea can also be exacerbated by the time change. Chronic sleep deprivation can affect attention levels, reaction time and mood, leading to decreased productivity at work, increased family stress, and potential health problems, according to the American Academy of Sleep Medicine (AASM).

The amount of sleep needed for good health and optimum daytime performance varies by age: preschoolers need 11 to 13 hours a night; school-age children should get 10 to 11 hours; teens must have at least nine hours; and adults should get seven to eight hours each night.

The AASM offers these tips for a good night's sleep:

- **Don't exercise or have caffeine, alcohol, nicotine or heavy meals close to bedtime.**
- **It's fine to eat a small snack before bedtime to avoid going to sleep hungry.**
- **Follow a consistent bedtime routine.**
- **Keep your bedroom quiet, dark and cool.**
- **Don't sleep in on the weekends. That just makes it harder to wake up on Monday.**
- **Try to spend time outside during the daytime if weather permits.**

http://healthyliving.msn.com/health-wellness/sleep/as-clocks-turn-back-on-sunday-think-about-better-sleep

FAMILY-CENTERED CARE

Family-centered care acknowledges and uses the family's knowledge of their family member's condition and their skills in communicating with and caring for their family member. It emphasizes the importance of keeping family members informed about their loved one's condition, prognosis, and treatment. Family-centered care encourages family presence during procedures.

Families desire to be kept informed, to have their questions answered and to participate in their loved one's care. They generally object to processes that make them feel helpless, uninformed or uninvolved. Patients generally want to feel assured that they are receiving the care and treatment they need and desire to be comforted and supported by their families during care. Meeting the family's needs can help reduce patient and family anxiety.

Here are a few examples of a family-centered care features**: comfortable sleeping space for parent; a desk with data ports and internet access; Caregiver stations located closer to patient rooms; easy-to-follow directional signs throughout the hospital; Ample, convenient parking; Sibling center; Child-friendly furniture and play tables in waiting areas.**

FAMILY PRESENCE WHILE TRANSFERING

Provide family members with options whenever possible. Helping families to restore a sense of control can decrease patient and family member anxiety and combativeness. Allow a family member to accompany the patient in the ambulance when possible. Use the family as a source of assistance to patient care by providing information (pertinent history, normal level of consciousness, special developmental concerns, dominant hand, best known IV site, etc.) and comfort (hold the patient's hand, reassuring the patient, singing a favorite song, comforting the patient during procedures, etc.).

Be diligent in meeting the family's information needs. Introduce the patient and the family to the health care professional receiving the patient and identify a transition team member to the family. Give the family the option to listen to your prehospital care report. Talk to the family before you leave and explain the outcome of your care with clear, honest dialogue. Say goodbye to the family.

INVOLVE FAMILY MEMBERS IN LOCAL EMS TRAINING PROGRAMS:

Provide programs in your community to help prevent or reduce the extent of injury such as bike helmet programs, child safety seat programs, and bystander care programs.

Teach Emergency Medical Providers (ECP) at all levels the value of family participation. Involve family members, including patients, parents and siblings, in training programs. Seek family member participation on committees and advisory councils designed to guide health care organizations and create public policy.

Provide orientation and support for family representatives to help them fully participate. Identify local EMS consumers with interest in sharing their experiences. Work with the local primary care community to identify families of children with special health care needs in your community that are potential EMS consumer-educators.

Involve local hospice programs and organ procurement programs in continuing education classes. Encourage other local EMS training programs to incorporate family-centered care practices into their elective curriculums.

TRIVIA CONTEST:

First 3 to answer the questions wins a free Crash Card-Pediatric Emergency Resuscitation Guide
Email rsuzor@mt.gov)

- **What does a score of three on the Glasgow Coma Scale indicate?**
- **What helps increase pediatric survival rates for cardiac arrest?**
- **What does the acronym PURPLE stand for?**

AAP CHIC Virtual Grand Rounds on Telehealth

The American Academy of Pediatrics' (AAP) Child Health Informatics Center (CHIC) has developed Technology Virtual Grand Rounds (VGRs) to provide education on topics in telehealth and health information technology (HIT) relevant to the profession of pediatrics. Each VGR will feature telehealth and HIT professionals who will guide pediatricians and subspecialists in using telehealth and HIT within their practices, communities, and institutions. http://www2.aap.org/informatics/CHIC.html

TRAINING RESOURCES:

Register Now for Missoula ASD Seminar

On March 22, 2014, ChildWise Institute will bring together experts in Missoula to present on issues pertaining to Autism Spectrum Disorders in Children. This conference is designed to expand understanding and awareness of Autism Spectrum Disorders in children and develop competencies for parents, mental health professionals, teachers and healthcare providers. Participants will be able to better understand and treat children diagnosed with symptoms on the Autism Spectrum Disorder (ASD). Social, emotional, behavioral and medical factors affecting children with ASD will be discussed. In addition, this learning seminar will identify ways to collaborate and integrate services from multiple agencies.

http://campaign.r20.constantcontact.com/render?ca=95c034d2-99ee-4332-b1e2-d17d8674bd91&c=0caac320-40db-11e3-a0bb-d4ae526edc76&ch=0ee39c20-40db-11e3-a0dd-d4ae526edc76

ANNOUNCING: LAUNCH OF NEW TA CENTER WEBSITE

On behalf of the U.S. Department of Education's (ED) Office of Safe and Healthy Students (OSHS), the REMS TA Center is excited to announce the launch of a newly redesigned website, http://rems.ed.gov.

The innovative website contains the latest information and resources for developing, maintaining, and enhancing high-quality emergency operations plans (EOPs) for schools and institutions of higher education (IHEs). It offers new accessibility to the recently released Federal guidance on EOP development, including the recommended six step planning process and key topics that support EOP development, such as information sharing, school climate, *active shooter* situations, and psychological first aid. The website has information customizable to the specific needs of your school, school district, or IHE.

Virtual Trainings, including downloadable webinars delivered by experts in the field; and A virtual **Tool Box** of resources developed by school and IHE emergency managers, and containing sample planning guidelines or policies; organizational charts; memorandums of understanding (MOU); and additional information relevant to your emergency operations planning needs.

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